



TOWN OF DAVIE EMPLOYEE REPORT OF INJURY

Department: _____ Division/Unit: _____ Position Title: _____

Employee Name:	Date of injury:	Time :	<input type="checkbox"/> AM <input type="checkbox"/> PM
Address where I report to work:		Place where injury occurred:	
Work Phone #:	Social Security #:	D.O.B.:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Shift:
Type of injury or illness and part of body affected:			
Do you need medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> NO			
Employee: Describe fully what you were doing when you were injured and how your injury occurs:			
What Personal Protective Equipment were you using?			
Name Witness(es): (include phone numbers if not co-employees):			
Any person who knowingly and with intent to injure, defraud, or deceive any employer or co-employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a crime. I have reviewed, understand and acknowledge all the above.			
Employee Signature:		Date:	

SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

To whom was injury/illness reported?	Date First Report:
Supervisors description of how injury occurred:	
Was Employee using issued <i>Personal Protective Equipment</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> NO PPE for Job:	
Was Employee following <i>Safe Work Rules</i> and/or Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> NO Explain	
What actions of the <i>employee</i> contributed to this accident?	
What actions of <i>other employees</i> contributed to this accident?	
Describe recommendations for the prevention of future such Incidents?(include any actions already taken):	
Was the employee sent off-site for medical? <input type="checkbox"/> Yes <input type="checkbox"/> NO	Where:
Has Employee Return To Work? <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted Duty <input type="checkbox"/> Sent Home by Doctor	
Date returned to work: _____ or Date expected to return to work: _____	
I have inspected the scene of the injury. <input type="checkbox"/> Yes <input type="checkbox"/> NO Explain	
Completed By:	(Signature) _____ Date: _____
Reviewed By Department Head:	(Signature) _____ Date: _____

(Attach Additional Sheets if Necessary)

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